Drug free Treatment and Rehabilitation for Drug Users

USAID-funded Drug Demand Reduction Program in Uzbekistan, Tajikistan, and the Ferghana Valley Region of Kyrgyzstan (DDRP)

DDRP BEST PRACTICE COLLECTION

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DDRP best practice collection series:

- **Drug free Treatment and Rehabilitation for Drug Users**
- Drug Demand Reduction Program
- Unique Identifier Code
- "Sister to Sister"
- Youth Power Centers
- Drug Demand Reduction Education and Referral of Migrants
- Treatment Readiness for Drug Users
- Drug free Public Social Spaces
- "Break the Cycle"
- Positive Youth Development

This Model was developed by **Andrey Zheluk** and **Dave Burrows** of AIDS Projects Management Group (APMG), http://www.aidsprojects.com, in cooperation with the DDRP specialists: **Galina Karmanova** (DDRP Chief of Party), **Yusup Magdiyev** (DDRP Country Director in Uzbekistan), **Dmitry Subotin** (DDRP/PSI Uzbekistan Drug Specialist), **Nigora Abidjanova** (DDRP Advisor in Tajikistan), **Umed Rashidov** (DDRP Director in Tajikistan), **Vladimir Magkoev** (DDRP/OSI Tajikistan Program Coordinator), **Aisuluu Bolotbaeva** (Public Health Program Coordinator, Soros Foundation Kyrgyzstan), **Oksana Korneo** (AOSI Executive Director), **Rustam Alymov** (DDRP Regional Program Coordinator) and **Timur Alexandrov** (DDRP Public Relations Coordinator).

INTRODUCTION AND OVERVIEW

The USAID-funded Drug Demand Reduction Program (DDRP) aims to address social problems among vulnerable populations involved in or at risk of involvement in drug use in Central Asia. DDRP activities in Uzbekistan, Tajikistan and the Ferghana Valley Region of Kyrgyzstan are a response to the dramatic rise in opiate injection in the region.

The term "drug demand reduction" is used to describe policies or programs aimed at reducing the consumer demand for narcotic drugs and psychotropic substances covered by international drug control conventions [1]. The countries covered under this program have experienced significant increases in opiate consumption due to geography and recent socio-political events including the collapse of the Soviet Union and the Afghan conflict. Heroin transiting through these countries has created epidemics of drug use, undermining already fragile economies and threatening to overwhelm health systems with HIV. This has also occurred in other nearby former Soviet republics. DDRP's mission is to engage all levels of society in reducing demand for heroin and other opiates. The program began in 2002 and will cease in 2007.

The Drug Demand Reduction Program involves a network of leading international organizations active in HIV prevention and drug demand reduction in the region.

The key components of DDRP are:

- educating target populations on drug-related issues
- promoting healthy lifestyles
- providing access to alternative occupational and leisure activities
- assisting in solving social problems
- supporting the development of pragmatic drug demand reduction strategies at national and local levels.

This Drug-Free Treatment and Rehabilitation for Drug Users Model is one of ten developed under DDRP for replication and contribution to HIV and drug demand reduction policy and program development in the Central Asian region.

What is the DDRP DrugFree Treatment and Rehabilitation for Drug Users Model?

The DDRP implemented ten drug free treatment and rehabilitation projects in Kyrgyzstan, Tajikistan and Uzbekistan. Five sites were visited to capture the experience of these projects. The lessons learned were distilled to produce this DDRP Model.

DDRP drugfree treatment and rehabilitation projects were targeted at dependent heroin/opiates injectors who had made a decision to stop using drugs and turned for help to the DDRP drug-free treatment and rehabilitation program.

Clients could self-refer to the project for the following assistance:

- To cease drug use;
- To reduce the symptoms associated with withdrawal;
- To remain drug-free after a course of pharmacologically-assisted detoxification.

If a client ceases drug use after entering the drug-free treatment and rehabilitation program, the program offers relief from withdrawal symptoms in the form of auricular acupuncture as per the U.S. National Acupuncture Detoxification Association (NADA) guidelines. In addition, relaxation assistance includes phytotherapy (traditional herbal medicine), natural hot water springs, specialist dependency counseling, and the support of peers taking the course of inpatient rehabilitation. Where the projects are located within a

medical facility, pharmacological detoxification may be offered. The provision of services depends on the resources available to the individual organization delivering the Drug-Free Treatment and Rehabilitation program.

In many projects, the 12-step approach is used, most commonly in the format used by Narcotics Anonymous (NA), with counselors acting as the core of the program.

Treatment and rehabilitation services include psychological assistance and psychotherapy aimed at enhancing individual patients' ability to overcome their drug dependency and develop work skills through occupational therapy in the form of physical labor.

There were two main features of the drug-free treatment and rehabilitation approach in all projects:

- A therapeutic environment, characterized by positive, supportive, non-stigmatizing staff attitudes towards patients, and strong peer support among patients undergoing the course of rehabilitation.
- The support of specialist dependency counselors dedicated to the development and realization of individual behavior change plans. In addition, counselors also helped to strengthen individuals' commitments to adhere to their plans.

Thus, Drug-Free Treatment and Rehabilitation Programs provide distinct phases of holistic and culturally appropriate care to address the bio-psycho-social aspects of heroin/opiate dependence. Treatment components may include: medically and psychologically supervised detoxification within the context of peer-based support; a strengths-based approach to treatment where the social environment encourages personal growth and development; daily psycho-educational group work that provides the drug dependent individual with the opportunity to learn about and reflect on the bio-psycho-social nature of his or her addiction and its management. Adjuncts to treatment may include: talks by former drug users, 12-step meetings, life skills development, creative activities, exercise, stress reduction, yoga, ego strengthening, and self-regulation as well as peer community work

12-step training session, Tashkent, Uzbekistan

and drug-free social and recreational activities. As part of comprehensive treatment and rehabilitation, crisis intervention, culturally appropriate support, education, and therapy should be available and accessible to address drug-related problems and to foster and rebuild family relationships, paving the way for the recovering individual's reintegration into family and community. A comprehensive and effective approach to treatment recognizes the complex and often chronic nature of heroin/opiate dependence and provides treatment plans created in collaboration with individual clients, allowing them to set realistic goals for change and move at their own pace. Phases of treatment may include:

- Early counseling and assessment where treatment strategies are appropriately matched to the stages of readiness for change.
- An intensive phase of detoxification and treatment, where peer-oriented support, professional help, and psycho-educational individual and group counseling and related activities form a collective "scaffolding" around the individual in the early stages of personal growth and development and reliance on mutual help as an alternative to heroin/opiate use.
- A second phase, once early recovery is underway, can focus on integration into autonomous networks of mutual help, the development of knowledge, skills and capacity for relapse prevention, vocational training, life skills development, and reintegration into family and community. Psycho-social tracks of treatment and rehabilitation can be targeted to the needs of select populations: youth, street involved youth, women with dependents, husbands and fathers, sex workers, and people living with HIV.
- These initial phases of residential treatment and rehabilitation can be followed by a 'stepped down' approach where longer-term rehabilitation options are matched to individual needs. Options in this phase can include outpatient treatment components, volunteer opportunities within the treatment context, job training activities, regular participation in autonomous 12-step networks, or longer-term residency in a half way house, which is a self-sustaining, drug-free peer-driven community setting. In this phase, the focus is on relapse prevention and support to live free of heroin/opiate dependence through informal mutual support networks, vocational training, education, and life skills development appropriate to the select population.

BENEFITS OF THE DRUG-FREE TREATMENT AND REHABILITATION FOR DRUG USERS MODEL

Provision of anonymous services

Anonymous service provision was critical to the success of the DDRP Drug-Free Treatment and Rehabilitation for Drug Users Model. The projects demonstrated the effectiveness of close integration with outreach-based treatment readiness in motivating injecting drug users with education, advice and referrals aimed at changing their risk behaviors [2].

The Unique Identifier Code (UIC) developed through the DDRP allowed clients to be referred anonymously and receive free treatment and rehabilitation anonymously. The UIC was part of a comprehensive system within DDRP Drug-Free Treatment and Rehabilitation that ensured client anonymity when working with at-risk and drug-using populations. This was particularly the case in service locations outside national capitals, where significant long-term stigma and discrimination associated with drug use and HIV can affect not only clients but also their families. (Please refer to the DDRP UIC Model in this series for additional information.)

By contrast, government drug treatment (narcology) clinics require individuals to be registered as drug users. Furthermore, treatment in government -run drug treatment clinics consists of short-term pharmacologically-assisted detoxification only. Many medical staff and clients regard compulsory registration of drug users and detoxification-only approaches as significant disincentives to enter governmen-funded drug treatment.

Anonymous drug-free treatment and rehabilitation was offered at all sites and universally praised by both clients and medical staff as one of the most important incentives leading drug dependent individuals to seek help through drug free treatment and rehabilitation projects.

The DDRP projects were the evidence based interventions tailored to the local environment

Local professionals strongly praised the DDRP for being the donor program in the region to extensively support rehabilitation and provide effective training in contemporary treatment techniques. The projects (together with other DDRP projects such as treatment readiness and those addressing sex workers) provided a continuum of care from outreach work through to treatment and reintegration into society. In addition to successfully building capacity among local drug treatment professionals, the DDRP projects provided an opportunity for interventions to be modified to local conditions. For example, at several sites in southern Kyrgyzstan, rehabilitation projects were oriented toward manual labor rather than cognitive methods after testing the usefulness of various approaches.

Benefits to individuals

The drug-free treatment and rehabilitation projects offered drug dependent individuals significant benefits. Central to reducing the demand for drugs is the treatment of dependent drug users. However, drug treatment in most Central Asian countries generally remains limited by Soviet-era detoxification-only practices and a lack of resources. In addition to anonymity, the extended stay residential programs provided clients with genuine opportunities to cease injecting drug use. Aside from government drug treatment programs, the DDRP projects were the only no-cost option available in Uzbekistan, Tajikistan, and Kyrgyzstan.

The projects' focus on integration of cognitive, medical and social aspects of drug treatment and rehabilitation was consistent with international evidence. Rather than clients being forced out into their previous lives at the end of a course of rehabilitation, relapse prevention interventions such as halfway houses and 12-step interventions were incorporated into most projects. The DDRP DrugFree Treatment and Rehabilitation approach was widely praised by drug treatment staff and clients as a unique project that offered clients a "way out of the labyrinth."

Benefits to families and codependents

In each DDRP project reviewed, education was undertaken in residential therapeutic communities and targeted both at drug users and codependents (including families of drug users). Family conflict is generally regarded as ex-

acerbating drug dependence. Limited contact with families and codependents was permitted at all sites. Codependents' relationships with the drug user may influence the drug user's behavior, and counseling interventions were therefore regarded as an important part of the rehabilitation intervention at all sites.

View of opiate dependence as a chronic relapsing disease

Within the DDRP DrugFree Treatment and Rehabilitation projects, interventions focused on motivating individuals toward long-term abstinence from drug use. While all projects sought to equip clients with the cognitive and emotional resilience to withstand relapse, international evidence suggests injecting drug use is closer to chronic disease than a temporary affliction [3].

The chronic relapsing nature of opiate dependence is caused by a confluence of genetic, biological, behavioral and environmental factors. Detoxification treatment alone fails to address the complex factors underlying and surrounding the disorder. Heroin use also produces long-term biological changes, as well as medical, social and occupational difficulties that put former drug users at great risk of relapse. Treatment should thus be considered a long-term process. Furthermore, poverty, psychiatric problems and lack of social supports all increase the chances of relapse after treatment. The difficult social and economic conditions in Central Asia and trauma following events such as the civil war in Tajikistan also make it more difficult for people to stop using drugs.

Thus, rather than facing a punitive attitude, individuals seeking to resume drugfree treatment would be readmitted, subject to several conditions. At Musaada in Kyrgyzstan, for example, clients were readmitted to the next group, if breach of contract or relapse occurred, based on testing of their urine to confirm their drug-free status.

LITERATURE REVIEW

This is a brief literature review covering the role of treatment and rehabilitation in drug demand reduction. Treatment for heroin dependence is a complex process, and an extensive review of the evidence underpinning all interventions is not possible in this document. This is an overview of specific theoretical assumptions underpinning the DDRP Drug-Free Treatment and Rehabilitation for Drug Users Model.

Objectives of drug dependence treatment

While dependence is a chronic relapsing disease like diabetes, many drug users and their families (and many drug treatment professionals) expect treatment to provide long-term stable abstinence, as if treatment is a cure for an acute disease [3]. Contemporary drug treatment methods have several goals. These are: to maintain the physiological and emotional improvements obtained during detoxification; to maintain reduced drug use or to assist in ongoing cessation of use; to motivate behaviors that are incompatible with drug use; and to support improved personal health, improved social function and reduced threats to public health [4].

Because of the chronic relapsing nature of drug dependence, achieving abstinence is often a lengthy and difficult process for many people [5]. Dropouts and relapse from residential programs are common. Effective drug treatment programs address these issues through relapse prevention education and acceptance of readmissions after relapse.

Detoxification and rehabilitation

There are several types of drug treatment for heroin users. Most methods last less than six months and include residential therapy and drug-free outpatient therapy. (Longer-term methods such as drug opioid substitution therapy do not have abstinence from drug use as their primary aim.) Stable abstinence or reduced drug use is achieved in two phases. First, a detoxification phase, in which an individual progressively stops heroin consumption, and second, relapse prevention, in which abstinence or reduced drug use must be maintained [6].

Detoxification does not address the underlying disorder. The medical, social and occupational difficulties that develop during dependence do not disappear once a person has been detoxified. Interventions are a long-term

process, with success unlikely from a single course of treatment. Factors such as low socioeconomic status, concurrent psychiatric condition and lack of social supports for continuing abstinence are associated with relapse after treatment [7]. In a study of drug treatment in two Russian cities, the local drug treatment system, based mainly on detoxification with no rehabilitation or onward referral, produced poor outcomes. The study suggested that injectors have little trust in the treatment system, and associate treatment with high failure rates, short remissions, and continuing drug use [8].

There is strong evidence for the benefits of residential programs [9,10,11]. In a large study of U.S. residential rehabilitation outcomes, the number of individuals who used heroin at least once per week was reduced from 17 percent to 6 percent, with significantly reduced involvement in crime [12]. Effective behavioral treatments for heroin can include residential and outpatient approaches. Both behavioral and pharmacological treatments can help to increase employment rates, lower risk of HIV and reduce criminal behavior [13].

Role of codependents

Heroin dependence affects both drug users and their significant others such as spouses and families (codependents). There is research to suggest that partners and families of drug users may help or hinder treatment and rehabilitation [14]. Further, the nature of codependents' relationships with the drug user may limit their potential influence over the drug user's behavior [15]. In the Central Asian context, rehabilitation services refer to families more frequently than partners as codependents.

Family conflict and peer group influences increase the likelihood of injecting drug use and illegal activity. There is evidence to support an emphasis on reducing conflict among family members, improving relationships with peers, and replacing deviant friendships with others that encourage treatment participation and conformity to social norms [16]. In addition, drug treatment can help family functioning. A study of methadone use found fewer family crises in the first few months after commencing treatment, with fewer social and drug use-associated problems [17].

A study of heroin dependent university students in Pakistan showed that the drug dependent individuals felt more family stress than non-addicts and were influenced by drug using peers [18]. Similarly, a Croatian study of adolescent drug use found dependent individuals came mostly from intact and higher income families and emphasized the importance of parental rearing practices on drug dependency [19]. In a U.S. study of a five-year follow-up of

post-rehabilitation clients who were in successful recovery, all attributed their success to personal motivation, treatment experiences, religion/spirituality, and paid employment. Clients placed particular value on the support of family and close friends in maintaining their drug-free status [20].

Therapeutic communities

Therapeutic communities are a popular treatment for the rehabilitation of drug users in the United States and Europe. Therapeutic communities are structured residential programs typically lasting 6 to 12 months that focus on re-socializing individuals to a drug- and crime-free lifestyle [21]. The support of social networks is important in a rehabilitation setting [22]. There is evidence that outcomes for women are improved in separate, or gender-adapted therapeutic interventions [23,24]. However, there is limited evidence that therapeutic communities are superior to other residential treatment, or that one type of therapeutic community is better than another [25].

HIV and blood-borne diseases

One of the goals of treatment and rehabilitation is to prevent the transmission of HIV and blood-borne viruses. Drug dependence treatment can help to prevent HIV through reducing injecting drug use, reducing sharing of injecting equipment, reducing sexual risk behaviors and providing opportunities for HIV education and medical care [26].

Soviet approaches to drug user registration and treatment

Across much of Central Asia and the former Soviet Union, Soviet approaches to drug treatment, including registration ("uchyot") of drug users still applies. In the Soviet Union, drug users were officially registered, and their names passed to the police. If they were detained on a minor charge, they were required to submit to treatment, which was regarded as the alternative to a custodial sentence. Addicts in custody also had to undergo a form of compulsory treatment (labor therapy) in a correctional institution. In addition, they were required to then report back to narcology clinics or be subjected to regular home visits for evaluation [27].

There is current evidence from non-Central Asian former Soviet republics that police rely on drug users as important sources of information about drug trafficking and other crimes. Deliberate targeting of drug users for registration and as police informants may heighten HIV risk for drug users, who may fear seeking HIV prevention services, or the taking of measures that would expose them to arrest [28].

INDIVIDUAL PROJECT DESCRIPTIONS

This section provides an overview of five sites reviewed during the development of this DDRP DrugFree Treatment and Rehabilitation for Drug Users Model document. Please refer to the List of all DDRP-funded drugfree treatment and rehabilitation projects.

NGO Musaada, Osh, Kyrgyzstan

Osh is an ancient Silk Road city in the Ferghana Valley of southern Kyrgyzstan, near the border with Uzbekistan. It has an ethnically mixed population of about 214,000 (2006), made up of Kyrgyz, Uzbeks and Tajiks. Osh, the second largest city in Kyrgyzstan, is regarded as a more religious and conservative city than Bishkek, the national capital. Osh has several very large outdoor markets that draw customers from a broad area. The city also lies on major drug routes from Afghanistan and has one of the highest rates of injecting drug use, commercial sex work and HIV infection in Kyrgyzstan. In Osh city in April 2006, there were 1,133 registered injecting drug users and 1,550 in Osh province. The estimated number of injecting drug users across the province was 20,000. Of reported HIV cases, 90 percent were among injecting drug users.

NGO Musaada conducted one of two DDRP drug-free treatment and rehabilitation projects in Osh. The director, a drug treatment specialist, originally developed a therapeutic community for drug users following a visit to Monar in Poland. The regional administration provided Musaada with premises, and renovation was undertaken with the assistance of clients. Musaada aimed to stabilize individuals' abstinence from drug use through long-term, anonymous and drug-free residential rehabilitation.

Clients signed agreements for a minimum of three months, with the average length of stay being six months. Some individuals stayed 12 to 18 months. Clients were mainly aged 25-54 years, 80 percent had been to prison, and most were illiterate manual laborers. The NGO had few female clients. However, all female clients were also sex workers. If a breach of contract or relapse occurred, Musaada would readmit clients to the next group if urine drug testing was undertaken to ensure compliance.

Services provided at Musaada were carried out with a therapeutic community philosophy. This description of services should not, therefore, be interpreted as a series of discrete activities, but as an environment within which all activities and social interaction was consciously designed. Within this environment, it was the interplay of services and daily interactions that constituted the drug-free treatment rehabilitation intervention over a period lasting several months

Sport facilities at the NGO Musaada, Osh, Kyrgyzstan

Significant elements of the therapeutic approach at the NGO Musaada included:

- *Tengrianstvo*

  The traditional Kyrgyz nomad philosophy strongly underpinned Musaada's activities. Musaada described it as easily compatible with Islam and Christianity. Conversely, only the first three steps of the 12-step approach were regarded as culturally appropriate.

Resting room at the rehabilitation center, NGO Musaada, Osh, Kyrgyzstan

- *Structured individual daily programs*

  These were based on agreement in a therapeutic contract not to engage in sex, violence or use drugs or alcohol. In the mornings, clients started with cold water baths, followed by group psychology counseling sessions. In the afternoons, clients undertook group psychotherapy until 16:00. After 16:00, clients had the choice of physical work or sports training for two hours. In the evenings, clients ate dinner at 18:00, then undertook art therapy, acupuncture, holotropic breathwork, (psychotherapeutic deliberate hyperventilation and relaxation) and motivational sessions. Scheduled activities aimed to help clients to achieve medication-free sleep.

- *Individual and group counseling*
  Individual counseling was generally regarded as inferior to group counseling. Furthermore, group counseling was regarded as providing benefits through maintaining group norms and discipline.

- *Codependents*
  No contact with codependents was permitted during the first two weeks of rehabilitation. Parents frequently made referrals to Musaada, but tried to maintain secrecy. A high degree of family stigma associated with having a drug using relative was noted.

- *Summer "halfway house" camp*
  At time of review in mid-2006, eight long-term clients were living in a halfway house, in yurts, in an inaccessible area in the nearby mountains for the entire summer.

- *Excursions*
  Every Sunday, clients went on excursions outside the city, into nearby forests, lakes and mountains.

- *Anti-relapse "marathons"*
  At the request of former clients, all the former clients who have completed rehabilitation gathered at Musaada to work together and socialize once or twice per year. This was widely regarded by clients as a positive anti-relapse measure.

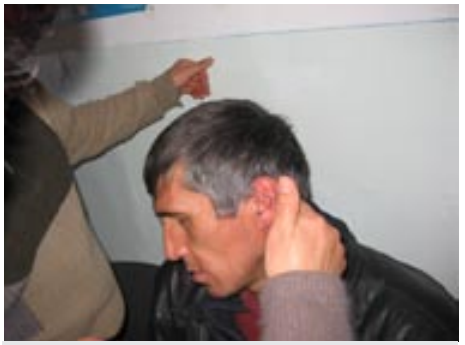
- *HIV testing*
  Musaada encouraged voluntary counseling and testing (VCT). Many clients did not wish to know their status. From the beginning of the DDRP project, 12 people learned of their HIV positive status while resident at Musaada.

- *Infection control*
  The project strongly encouraged enforcement of infection control for hepatitis with individual toothbrushes and razor blades.

- *Onward referrals*
  Many poor clients, or those without social support, did not wish to leave Musaada. A halfway house operated on the Musaada site and provided accommodation and small self-generated wages for individuals with no housing, employment or social support at the end of their rehabilitation program.

Musaada had seven paid staff. These were a director, a drug treatment specialist, a psychotherapist, two psychologists, managers and a counselor. In addition, two long-term outreach workers continue to undertake unpaid outreach work.

Osh Narcology Center, Osh, Kyrgyzstan



Auricular acupuncture session,
Osh Narcology Center, Kyrgyzstan

The Osh Narcology Center has conducted one of the two DDRP drug-free treatment and rehabilitation projects in Osh since 2004.

The project aimed to motivate and support drug dependent individuals to undertake drug-free treatment and rehabilitation. The Center aimed to keep clients busy in an emotionally and physically comfortable environment. The Osh Narcology Center project was closely associated with the DDRP-funded treatment readiness project undertaken by the NGO "Parents Against Drugs." The drug-free treatment and rehabilitation project provided at least three months of residential treatment, which could be undertaken anonymously without government registration as an injecting drug user. No antidepressants or other medications were used in the process.

Clients were up to 45 years old. There were few females, though, if referred, they were given priority for detoxification and rehabilitation. Clients could be admitted following detoxification or if they could demonstrate three months of clean urine tests. A full course of rehabilitation, including detoxification, was intended to last three months. From the time the DDRP project commenced, more than half of all enrolled clients had completed the full treatment course. Those who left did so primarily for economic and personal reasons or for contract breaches including relapses.

Services at the Osh Narcology Center were provided within a therapeutic community model. Significant elements of the therapeutic approach at the Osh Narcology Center included:

- *Casework-like approach*
  Social workers accompanied clients through the process of detoxification and rehabilitation, maintained contact after finishing rehabilitation, and provided assistance with documents, employment and housing. Clients frequently chose to maintain contact after rehabilitation.

- *Daily schedule*
  Each morning consisted of physical activities, while afternoons were dedicated to counseling activities with psychotherapists and psychologists, both individually and in groups. After 16:00, clients were given free time. In addition each person had his or her own schedule for household tasks such as cooking and cleaning. Additional activities and services included acupuncture, art therapy, an exercise hall with weights, treatment of somatic medical problems and referral to medical specialists as needed.

- *Codependents and home visits*
  Activities with codependents were regarded as integral to client success. Clients could visit their homes by mutual agreement and on condition of urine testing for drug use on return.

- *Physical labor*
  Physical labor was regarded as most appropriate and more effective than cognitive approaches with the mostly poorly educated target group.

The Osh Narcology Center project employed a director, a drug treatment specialist, a psychotherapist, a psychologist, a nurse, and a supervisor.

NGO Diaron, Djalal Abad, Kyrgyzstan

Djalal Abad is the administrative and economic center of Djalal Abad Province in southwestern Kyrgyzstan and has a population of about 105,000

(2001). It is situated at the northeastern end of the Ferghana Valley next to the Uzbek border. The unofficial rate of unemployment in Djalal Abad was approximately 70 percent. Soviet-era light manufacturing has ceased to function as has most of the agricultural sector, leaving the city's residents with the local market providing the single source of cash income. As a consequence, every second household has at least one male between the ages of 25 and 55 working as an illegal laborer in Russia or Kazakhstan.


At the rehabilitation center of Diaron public foundation, Djalal Abad, Kyrgyzstan

NGO Diaron is located on the grounds of a psychiatric hospital in Djalal Abad. In 2003, Diaron received its first grant from the Asian Development Bank to do capacity development at the hospital. In 2004, a grant from ZdravPlus, Counterpart and Soros Foundation further improved Diaron's facilities. At the time of review, Diaron was in receipt of two grants. The DDRP grant funded drug free treatment and rehabilitation, while a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) funded a youth project aimed at prevention of drug use among local university students.

The project provided residential treatment lasting at least three months, which could be undertaken anonymously, without government registration as an injecting drug user. No antidepressants or other medications were used in the rehabilitation process.

Most Diaron clients were approximately 30 years old but ranged between 20 and 50 years. Only a very small number of females participated in treatment. Most clients were referred from the DDRP-funded treatment readiness project implemented by NGO Healthy Generation but some came from state narcology clinics. Signed and verbal agreements were made at the beginning of treatment with a set of conditions. If conditions were breached, clients were expelled but could return with the next group intake.

Services provided at Diaron were provided as a therapeutic community model. Significant elements of the therapeutic approach at Diaron included:

- *Daily activities*
  Diaron aimed to keep clients constantly busy through a regular schedule, lasting five days per week. Activities started at 07:00, followed by breakfast, group psychotherapy and acupuncture. Lunch was prepared by clients with food supplied by the project. Lunch was followed by psychological counseling, conducted on an individual and group basis on alternate days. At 17:00, clients undertook routine cleaning, washing and self-care. This was followed by individual nurse consultations for minor medical complaints. Between 19:00 and 20:00, the evening meal was served, followed by sports training in the hall.

- *Codependents*
  Codependents were regarded as being equally in need of interventions from psychotherapists and narcologists in order to achieve sustainable client outcomes.

- *HIV testing*
  At the time of review, there were two HIV positive individuals in the center, both diagnosed while at Diaron. Voluntary Councelling and Testing (VCT) was encouraged and pre- and post-test counseling was provided. It was estimated that 30 percent of those that passed through the program are HIV positive. In 2005, 12 residents were diagnosed as HIV positive.

- *Halfway house*
  Diaron clients were involved in repairing a halfway house 20 kilometers outside Djalal Abad at the time of review. The halfway house provided longer term rehabilitation and social reintegration for clients.

Diaron employed a director, who is also a drug treatment specialist, a psychotherapist, a psychologist, a nurse, and counselors.

Republican Drug Treatment Center (RNC), Tashkent, Uzbekistan

The DDRP DrugFree Treatment and Rehabilitation project in Tashkent was based at the government-funded Republican Drug Treatment Center. Tashkent, the capital of Uzbekistan, is a city of 2 million people (2004) and has high rates of sex work and injecting drug use. Tashkent attracts many young unskilled workers, who seek to escape the high rural unemployment of Uzbek villages.


Sport room at the Republican Drug Treatment Center, Tashkent, Uzbekistan

The Republican Drug Treatment Center is located on the outskirts of Tashkent, approximately a 30-minute drive from the center of Tashkent. The RNC received its first DDRP funds in early 2004, after learning of DDRP through professional networks. Once funding had been received, the hospital administrators dedicated a floor as an additional demonstration of support. From a service delivery perspective, the center used prior experience to apply evidence-based practice to the project including entry and exit criteria, rigorous psychological assessment, and new psychotherapeutic techniques. DDRP funding provided a significant boost to service provision and to enhancing the professional capacity of the center, allowing for the creation of a therapeutic community. The project provided residential treatment lasting at least three months, which could be undertaken anonymously. No antidepressants or other medications were used in the rehabilitation process.

The RNC admitted drug dependent individuals in groups. Clients could be referred from any narcology center in Uzbekistan. Referrals were also made by word of mouth in drug user networks and by NGOs engaged in treatment readiness activities. At the time of admission, clients signed contracts, which included rules about cleanliness, cooking duties and other household tasks. A standard course of treatment lasted three months.

Services provided at the RNC were provided as a therapeutic community model. Significant elements of the therapeutic approach at the RNC included:

- *Daily activities*
  Cooking and cleaning tasks were undertaken by the therapeutic group, and the group was expected to maintain appropriate behavioral norms. Art therapy, holotropic breathwork and acupuncture were popular among clients. Many patients in poor physical condition eventually had the ability to overcome small challenges.

- *Individual and group psychotherapy*
  The project started with motivation and rational approaches to psychotherapy, then progressively taught clients what to do with this information. Group therapy including transactional analysis, gestalt therapy, body awareness techniques, and social skills training, was also provided as were as a range of other techniques including motivational interviewing, art therapy, and neurolinguistic programming. These techniques all aimed at enhancing clients' self-esteem.

- *Relapse prevention training*
  Many clients had passed through various rehabilitation programs several times. Relapse prevention training aimed at increasing each individual's resistance to relapse.

- *Codependents*
  The RNC actively engaged codependents in rehabilitation programs.

Project staff consisted of the director, who is a drug treatment specialist and psychotherapist, three psychologists, and an art therapist.

NGO DINA, Khujand, Tajikistan

Khujand is Tajikistan's second largest city and the administrative center of Sughd Province. This city of 149,000 (2000) is situated on the Syrdarya River at the south of the Ferghana Valley. The DDRP Drug Free Treatment and Rehabilitation project in Khujand was conducted by NGO DINA. Founded in 1998, DINA quickly succeeded in attracting the support of government and international donor organizations. Other DINA services include a counseling center, education center, and an information and analysis center engaged in advocacy, media and analytical work. DINA collaborated closely with the Sughd province administration to create a single system of institutions for HIV prevention, treatment and care of most vulnerable groups including injecting drug users, commercial sex workers and people living with HIV/AIDS.

Stet farm at the DINA rehabilitation center, Khujand, Tajikistan

The DINA Rehabilitation Center opened in 1999, on one hectare of land in the small village of Palass, some 20 minutes by automobile from Khujand. A labor commune was created on the same site in December 2004, with the support of the DDRP, to decrease the chances of relapse among individuals who had passed through treatment programs.

Labor therapy project allows its client to obtain vocational skills, Rehabilitation center DINA, Khujand, Tajikistan

The DDRP project at DINA involved the establishment of a labor commune for long-term rehabilitation of clients who had completed treatment. The project provided residential treatment lasting at least three months, which could be undertaken anonymously. No antidepressants or other medications were used in the rehabilitation process.

Services provided at DINA were provided as a therapeutic community model. Significant elements of the therapeutic approach at DINA included:

- *Labor commune*
  The DDRP funded a labor commune to provide social support for people who have finished treatment. Services included education in small business and farm work, construction of facilities and planting, care for animals and household tasks such as cooking and cleaning. The structuring of time was a very important part of the rehabilitation process. Every day rehabilitants got their individual duties at general morning meetings. The clients themselves took part in the process of task distribution. Other activities included physical exercises in a gymnasium and dances. The psychological interventions were mostly based on client-centered approaches such as counseling using motivational interviewing. The aim of interventions was the strengthening of clients' decisions to maintain sobriety as well as showing them ways to keep sober. Psychotherapy and psychological counseling were carried out in groups and individually. Auricular acupuncture sessions meeting National Acupuncture Detoxification Association, or NADA, protocol were also provided to the clients.

- *Links to regional administration*
  DINA had excellent links with regional administration, police, educational and health services.

- *Onward referrals*
  Employment opportunities and assistance with housing were undertaken through the DINA network whenever possible. Staff included a manager, a counselor and a drug treatment specialist on site. In addition, the labor commune had access to professional expertise, staff and resources of DINA and other organizations in Khujand, thanks to integration with the regional government.

LESSONS LEARNED

This section of the DDRP Drug Free Treatment and Rehabilitation for Drug Users Model provides an overview of general recommendations and lessons learned. The information in this section serves two purposes: first, to provide a services description, and second, to capture the best practices observed during the project process, which might serve as a guide in the Central Asian region. (The full detailed information for organizations seeking to implement the Drug Free Treatment and Rehabilitation projects is described in the separate DDRP publication "The DDRP's Treatment and Rehabilitation Improvement Manual.")

Location

- *Client anonymity*
  Private entrances to drug treatment facilities in cities were highly desirable. Locations outside of city boundaries are ideal, as they preserve client anonymity. In addition, these locations reduce the temptation for relapse and offer scope for the addition of new occupational therapy, sports and other facilities, all regarded as central to the rehabilitation process. DINA in Khujand was an example of such a facility. A secondary support facility, such as a halfway house, was being built outside Djalal Abad.

- *Co-location with psychiatric facilities*
  Co-location with psychiatric institutions was noted as a negative influence on client motivation in Djalal Abad.

Minimum standards for infrastructure

- *Physical infrastructure*
  Each site was extensively renovated, either as part of the DDRP project or through other donor projects. All sites undertook significant repairs to ensure an adequate level of comfort for clients. This was commonly referred to as an important factor in client motivation as word of mouth spread the news about the improved facilities to the target group of injecting drug users.

- *Utilities*
  In many sites in Central Asia, there are difficulties associated with providing a regular electricity supply and running water. Even in renovated state rehabilitation centers, services were always basic, with several single beds to a small room. These issues are not restricted to provincial cities.

- *Cold weather*
  Heroin dependent individuals frequently experience increased sensitivity to cold. The lack of electricity for lighting and heating jeopardizes the ability to deliver services. Back-up generators to ensure regular power supplies in winter should be considered as important to infrastructure as running water in motivating clients to commit to a residential rehabilitation program. At the drug-free treatment and rehabilitation project managed by DINA in Khujand, for example, seasonal factors strongly influenced service demand.

Participants of the seminar "Efficient methods and new approaches in drug use prevention among youth", Dushanbe, Tajikistan

Referral Partnerships

- *Relationships to treatment readiness and outreach services*
  Close relationships with treatment readiness projects and outreach services were essential, as they were one of the main sources of referrals. This was noted at all sites visited.

- *Relationships with detoxification projects*
  All sites strongly supported medical detoxification prior to rehabilitation. These were important referral sources. In addition, advocacy was frequently required for individuals who could not afford a repeat medical detoxification following relapse.

- *Onward referrals*
  Social reintegration through work, housing and long-term support was noted as requiring additional development in most sites. DINA in Khujand provided a model of how partnerships might work in practice in Central Asia.

Advocacy and service promotion

- *Organizational relationships*
  Close collaborative relationships with the local administration, mahallas, police, health administration, educational institutions and religious organizations were all central to initial project success. Pre-existing relationships from previous projects provided excellent foundations for undertaking new treatment interventions.

- *Roundtables*
  These were used as an advocacy and promotional technique at all sites visited. Representatives of government, media, police, NGOs, private industry and health were invited to promote new initiatives.

- *Mass media and police advocacy*
  Mass media and personal relationships can assist in advocacy and service promotion. Police advocacy, via education seminars and on behalf of individual clients, is useful as a promotional technique.

- *Promotion*
  Word of mouth in the drug user community was noted as the most effective promotion mechanism at all sites reviewed. Television was the most effective mass medium for service promotion. In addition to coverage of events and roundtables, low cost teletext television subtitles advertising local services were found to generate a high volume of inquiries in Djalal Abad. Promotions at discos, newspapers and radio can also be helpful as additional means to promote the services.

Client characteristics

Labor therapy, DINA rehabilitation center, Khujand, Tajikistan

- *Registration as drug users*
  Approximately 30 percent of the rehabilitation center clients were registered as drug users in Osh. Registration creates barriers for several years to work and study. In a small city, this has damaging effects.

- *Language and literacy*
  Russian is especially common among older clients, whereas lower levels of education and Russian language usage were found among younger groups.

- *Client aims*
  Not all wish to cease drug use. Older drug users, in particular, may wish to reduce their required dose, or otherwise regain some measure of control over their dependence.

- *Reasons for exiting drug-free treatment and rehabilitation*
  Economic issues and family issues were cited as reasons for program exit at all sites. Strong family pressure to earn income was noted at several sites.

- *Gender specific services*
  There was no mention of gender specific services. Generally a separate small room co-located in predominantly male facilities was the full extent of services for women.

Service delivery

- *Anonymity*
  Anonymity is absolutely essential. The UIC developed through the DDRP allowed for anonymous referral and receipt of treatment. This was offered at all sites and universally praised by both clients and medical staff as one of the most important elements of the Drug Free Treatment and Rehabilitation projects.

- *Detoxification*
  Detoxification was regarded as an essential precursor to program entry at all sites reviewed. Additional funds to provide repeat detoxification for individuals who relapse should be considered.

- *Client contracts and urine analysis*
  These were used to various extents at all sites to motivate and monitor drug abstinence.

- *Residential therapeutic communities*
  All services offered inpatient residential services over at least three months, underpinned by the therapeutic community concept. All organizations reported a full daily program of set client activities. Sufficient sports facilities, appropriate to young males, should be provided from project outset.

- *Specific activities*
  These included group and individual psychology and psychotherapy, acupuncture, relaxation, sports, occupational therapy, art therapy, massage, yoga, relaxation, and holotropic breathwork. Group therapy included transactional analysis, gestalt therapy, body awareness techniques, and social skills training. Other techniques included motivational interviewing, and neurolinguistic programming (NLP).

- *Cognitive counseling approaches*
  These may not be appropriate with clients who are illiterate and have worked only as manual laborers.

- *Codependents*
  A poor understanding of codependency among parents was noted in several locations. Many clients lived with parents. Parents were mentioned more frequently than wives or partners in discussions of codependents at all sites.

Case management
Social workers frequently followed clients from outreach-based motivation, through detoxification, rehabilitation and beyond. This was noted at several sites.

Post-discharge client monitoring
In Tashkent, client telephone numbers were recorded to allow active follow-up after discharge from rehabilitation, as no community-based post-rehabilitation service was available.

Employment and re-socialization
At most sites former clients were employed as workers in the rehabilitation process. Halfway houses in Musaada and DINA projects, in particular, provided long-term socialization, housing and employment extending more than 12 months if necessary.

Drug treatment professionals' preference for government services
Most medical professionals saw government service provision as generally preferable to NGO service provision because of the uncertainty associated with the long-term continuity of NGO projects. Equally, these professionals recognized that no government in the region was able to supply sufficient funds for drug-free treatment and rehabilitation.

Anonymity and crime
Several instances were mentioned of individuals entering anonymous treatment while facing criminal charges. Police negotiated formally with centers to ensure issues were resolved. Initial entry conditions required disclosure of any outstanding criminal issues, and failure to disclose these was regarded as a breach of rehabilitation conditions.

Seasonal referral patterns
Preparation for work in Russia as illegal migrants was seen as a cause of strong demand for services in the spring. Work in Russia was also seen as a reason many parents referred their sons for drug-free treatment and rehabilitation. Diaron in Djalal Abad reported that while many drug using individuals were in Russia, fear of police harassment stopped them from

using drugs. However, upon their return, many individuals had less fear, more money, and easily accessible heroin.

Staff and volunteer training
Contemporary rehabilitation techniques: Local professionals strongly praised the DDRP for being the donor program to extensively support rehabilitation from opiate dependence as a drug demand reduction intervention and for supporting staff training in contemporary interventions. This was noted at all sites reviewed.

Specific issues associated with training were
- Training in motivational interviewing: Client motivation was regarded as central to successful rehabilitation. Several sites suggested additional training of professionals in motivational interviewing would be of benefit.
- 12-step training: Additional 12-step training was regarded as desirable by many implementers in Central Asia.
- Psychotherapy training: The Pavlodar, Kazakhstan, approach was highly praised across the region. Intensive courses of up to 20 days were generally the preferred form of education.
- NADA Acupuncture Detoxification trainings: Several specialists from each country were trained in Auricular Acupuncture Detoxification according to NADA protocol.

Barriers to training
Outward migration of specialist medical staff to higher paid positions in Russia and Kazakhstan was noted in Osh and Djalal Abad. The medical faculty in Djalal Abad University was scheduled to close, depriving the city of medical expertise. At several sites, individuals who had been the most active volunteers in organizing the target group had died of AIDS.

Knowledge transfer
The use of face-to-face educational visits was widely regarded as an effective means of knowledge transfer. The Monar facility in Krakow, Poland, was frequently mentioned as an excellent program to visit. However, there was a general lack of access to Western academic databases and a lack of ongoing incorporation of evidence-based practice into projects.

- *Drug demand reduction principles*
  Staff in each organization received training in drug demand reduction at the commencement of each project. Additional training was provided throughout the project in drug demand reduction principles most relevant to their target group.

Monitoring and evaluation

- *UIC*

Anonymity was important at all sites and seen as a motivator of rehabilitation. The Unique Identifier Code (UIC) was used at all sites. It was regarded as a burdensome task in complex residential programs where multiple services were provided, but it provided a way to preserve anonymity while providing accurate data about services.

REPLICATION

This section of the model provides an overview of project results and suggestions for replication.

NGO Musaada, Osh, Kyrgyzstan

Musaada reported some initial difficulties with police harassment of clients. Roundtables and seminars assisted in the creation of positive relationships with senior local police.

Private companies have assisted Musaada by buying construction materials and electrical equipment to ensure stable power supplies for workshops. This suggests that limited forms of commercial sponsorship may be available to drug-free treatment and rehabilitation projects.

Several potential directions for service enhancement were noted at Musaada. Outreach-based acupuncture and overdose prevention in outreach were regarded as potential enhancements to motivational work. Horse therapy, based around the important role of horses in traditional nomadic Kyrgyz culture, was seen as offering rehabilitation potential. At the time of the field visit, Musaada had applied for non-DDRP funding for a drop-in center to facilitate client motivation and planned to increase their workshop capacity for income generation for longer term halfway house clients.

Osh Narcology Center, Osh, Kyrgyzstan

The Osh Narcological Service supported former clients through providing training, support and grant writing assistance to establish a 12-step project outside Osh.

Substitution therapy for HIV positive injecting drug users was felt to be a critical missing service. Out of 46 people in the center at the time of review, 30 percent were HIV positive and four were receiving anti-retroviral therapy. The Director of the Osh Narcology Center estimated that 3,000 people required substitution therapy, and 1,000 should be receiving highly active antiretroviral therapy, or HAART.

The cost of detoxification was regarded as an important factor limiting the pool of rehabilitation clients. A course of detoxification lasting between 15 and 20 days cost approximately USD40 in early 2006. This amount of money was regarded as being well beyond the reach of often destitute dependent drug users.

NGO Diaron, Djalal Abad, Kyrgyzstan

One "check" in Djalal Abad costs USD 1, but a dependent user might need 2-3 checks for a single dose. Thus financial incentives driven by the cost of heroin may influence clients' entry into rehabilitation.

Diaron clients were involved in repairing a halfway house 20 kilometers outside of Djalal Abad. The halfway house was intended to provide longer term rehabilitation and social reintegration for clients.

Republican Narcological Center, Tashkent, Uzbekistan

Art therapy was regarded as a particularly successful intervention. An exhibition of client art therapy works provided an opportunity to promote the center, to invite embassy staff and media, and to motivate clients. Several other DDRP-funded projects in the region noted the potential of art exhibitions in rehabilitation.

Internet access for clients was seen as a tool that could assist clients in both finding work and reestablishing their social lives.

NGO DINA, Khujand, Tajikistan

NGO DINA demonstrated successful integration of prevention, treatment readiness, detoxification and referral to treatment and rehabilitation. DINA further demonstrated the successful integration of donor funding, NGO advocacy, and government replication at an province-wide level.

GLOSSARY

Body awareness techniques: Physical relaxation techniques that aim to improve self awareness.

Chek: Single dose of heroin.

Drop-in center: A drop-in center is a site that provides drug demand reduction services to a specific target group, such as individuals in at-risk groups, active drug users and commercial sex workers. While some drop-in centers aim to facilitate social contact between clients and professional staff, other centers may offer at-risk individuals services such as food, washing and sleeping facilities. Drop-in centers for drug demand reduction generally aim to provide "low threshold services." That is, they have very open criteria and allow anyone who wishes to visit the center to do so.

Drug demand reduction: The term "drug demand reduction" is used to describe policies or programs directed towards reducing the consumer demand for narcotic drugs and psychotropic substances covered by the international drug control conventions (the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988). The distribution of these narcotic drugs and psychotropic substances is forbidden by law or limited to medical and pharmaceutical channels [30].

Gestalt therapy: A psychotherapy technique that focuses on improving patients' self-awareness.

Holotropic breathwork: A psychotherapeutic approach developed by Stanislav Grof. The method combines deliberate hyperventilation and relaxation while listening to evocative music in a supportive setting.

Narcological dispensary: Drug and alcohol treatment clinic.

Neurolinguistic Programming (NLP): Psychotherapeutic technique based on language patterns and body language cues on issues such as how subjective reality drives beliefs, perceptions and behaviors. Through behavior change, transforming beliefs, and treatment, the NLP approach suggests it may be possible to change beliefs and behaviors.

Social skills training: A general term for instruction conducted in behavioral areas that promotes more productive and positive interaction with others, and in so doing, promotes social acceptance.

Transactional analysis: In psychotherapy, transactional analysis utilizes a contract for specific changes desired by the client and involves the "Adult" in both the client and the clinician to sort out behaviors, emotions and thoughts that promote the development of full human potential.

Yamy: Locations where drug users gather. In Russian, this literally translates as "holes in the ground."

DDRP DRUG FREE TREATMENT AND REHABILITATION PROJECTS WERE IMPLEMENTED BY:

NGO Filadelfia Star
Mr. Gennady Temmoev
24/9 – 5/4 micro district, Angren, Uzbekistan
Tel.: (998 7166) 3-12-80
E-mail: filadelfiya_tg@mail.ru

NGO Komila
Ms. Gulkamar Bultaeva
40 H. Muradova str., Termez, Uzbekistan
Tel.: (998 376 22) 2-49-20
E-mail: sher_up@intal.u

NGO Diaron
Ms. Chinara Jusupova
91 Pushkin str., Djalal Abad, Kyrgyzstan
Tel.: (996 3722) 5-38-33
E-mail: chinara.ga@mail.ru

NGO Musaada
Mr. Isa Nurmamatov
14/15 Microdistrict Tuleiken, Osh, Kyrgyzstan
Tel.: (996 3222) 2-27-87, (996 502) 90-79-17,
E-mail: musaada@rambler.ru

Osh Narcology Center
Mr. Mamasobir Burkhanov
Isanova str., Osh, Kyrgyzstan
Tel.: (996 3222) 5-47-59
E-mail: oond51@mail.ru
E-mail: infoddrp@osi.tajik.net

NGO DINA
Mr. Sino Karimov
32 Microdistrict, building 59, apt. 29,
Khujand, Tajikistan
Tel.: (992 3422) 5-12-14
E-mail: dina-dd@mail.ru

NGO Buzurg
Mr. Nematullo Avezov
5/66 Rudaki str., Panjakent, Tajikistan
Tel.: (992 3475) 5-45-54
E-mail: buzurg77@mail.ru

NGO Volunteer
Mr. Maram Azizmamadov
135/1-3 Shirinshoh Shohtemura str.,
Khorugh, Tajikistan
Tel.: (992 352 20) 35-77
E-mail: Volunteer70@mail.ru

Republican Narcological Center
Mr. Gulam Burikhodjaev
Ms Natalia Baranova
Kibray district, Tashkent province, Uzbekistan
Tel.: (998 712) 60-43-11
E-mail: natabaranov@rambler.ru

Ferghana Province Narcological Dispensary
Mr. Ikromjon Vakhobov
8 Kolhoznaya str., Ferghana, Uzbekistan
Tel.: (998 3732) 22-75-79
E-mail: botirqodirov@mail.ru

DDRP DRUG FREE TREATMENT AND REHABILITATION CONTACTS

Alliance for Open Society International,
Almaty Branch
Ms. Oksana Korneo
Executive Director
97 Makataev Str., Almaty, 050004, Kazakhstan
Tel.: +7 (327) 278-02-22; Fax: 279-88-11
E-mail: ddrpinfo@aosi.kz

Alliance for Open Society International,
Almaty Branch,
Ms. Galina Karmanova
DDRP Chief of Party
33-a M. Yakubova Str.
Tashkent, 100031, Uzbekistan
Tel: (998 71) 120-43-35/36/37
Fax: (998 71) 120-43-37
E-mail: ddrpinfo@aosi.kz

Alliance for Open Society International,
Almaty Branch
Mr. Rustam Alymov
DDRP Regional Program Coordinator
97 Makataev Str., Almaty, 050004, Kazakhstan
Tel.: +7 (327) 278-02-22; Fax: 279-88-11
E-mail: ddrpinfo@aosi.kz

Tajikistan branch of the Open Society Institute – Assistance Foundation
Ms. Nigora Abidjanova
Advisor to DDRP in Tajikistan
37/1 Bokhtar Street, 4th floor,
Dushanbe, 734003, Tajikistan
Tel. (992 47) 441-07-45/50
Fax: (992 47) 441-07-29
E-mail: infoddrp@osi.tajik.net

Tajikistan branch of the Open Society Institute – Assistance Foundation
Mr. Umed Rashidov
DDRP Director in Tajikistan
37/1 Bokhtar Street, 4th floor,
Dushanbe, 734003, Tajikistan
Tel. (992 47) 441-07-45/50
Fax: (992 47) 441-07-29
E-mail: infoddrp@osi.tajik.net

Tajikistan branch of the Open Society Institute Assistance Foundation
Mr. Vladimir Magkoev
DDRP Program Coordinator
37/1 Bokhtar Street, 4th floor, Dushanbe, 734003, Tajikistan
Tel. (992 47) 441-07-45/50
Fax: (992 47) 441-07-29
E-mail: infoddrp@osi.tajik.net

Population Services International
Mr. Yusup Magdiev
DDRP Director in Uzbekistan
33-a M. Yakubova Str.
Tashkent, 100031, Uzbekistan
Tel: (998 71) 120-43-35/36/37
Fax: (998 71) 120-43-37
E-mail: questions@psi.kz

Population Services International
Mr. Dmitry Subotin
DDRP Drug Specialist
33-a M. Yakubova Str.
Tashkent, 100031, Uzbekistan
Tel: (998 71) 120-43-35/36/37
Fax: (998 71) 120-43-37
E-mail: questions@psi.kz

Soros Foundation Kyrgyzstan
Ms. Aisuluu Bolotbaeva
Public Health Programs Coordinator
55-a Logvinenko Str., Bishkek, Kyrgyzstan
Tel.: (996 312) 62-26-55; Fax: 66-34-48
E-mail: ddrpinfo@soros.kg

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Printed by Alexseev A.V.
Iskander Print House
103 Furmanov Street, Almaty, Kazakhstan
Tel.: +7(327)272-62-68, 261-55-45
E-mail: iskander@iskander.network.kz